BALLARD CHIROPRACTIC CLINIC

9015 HOLMAN RD NW STE 3 ● SEATTLE, WA 98117 ● (206) 782-8500 ● ERIC R. WECHSELBERGER, DC

Name:_____ Age:_____ Today's Date _____

Address:_____ Birth Date:_____ ❑ M ❑ F ❑ NB

City:_____ State:_____ Zip Code:_____

Contact Preference: ☐ Cell: _____ ☐ Bus: _____

☐ Home: _____ ☐ Email: _____

Employer:_____ Your Title:_____

❑ Married ❑ Single ❑ Partnered ❑ Widowed ❑ Divorced ❑ Separated Number of Children _____

Insurance Company:_____

Insurance billing will be handled out of this office. If you have an insurance card, please let us know and we will see that your insurance company receives the proper information to process your claims. For worker's injuries an Accident Form must be completed. Motor vehicle accident cases will be discussed in depth due to the complexity of such cases. An auto accident questionnaire must also be completed. We look forward to serving you!

CURRENT HEALTH CONDITION

Areas of Complaint:_____

_____

Condition Started on:_____ Other Doctors seen for this condition/treatment:_____

_____

Have you lost time from work? ❑ Yes ❑ No Dates:_____

Probable Cause

❑ On The Job Injury ❑ Motor Vehicle Accident ❑ Other Accident ❑ Other Reason

Explain: _____

_____

PAST HEALTH HISTORY

Major Surgery/Operations: ❑ Laminectomy ❑ Spinal Fusion ❑ Prostate ❑ Hernia ❑ Gall Bladder

❑ Hysterectomy Other:_____

Broken Bones:_____ Past Injuries or Accidents:_____

_____

Previous Chiropractic Care: ❑ Yes ❑ No

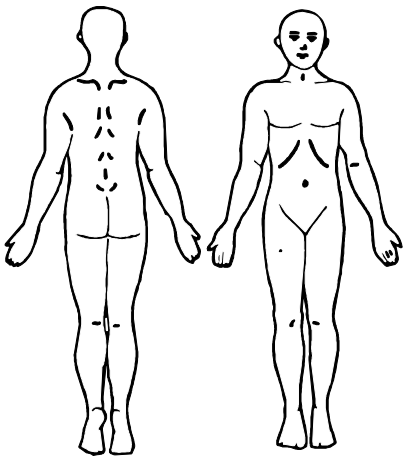
Doctor's Name and approximate date of last visit:_____

Have you been treated for any health condition in the last year? ❑ Yes ❑ No

If yes, please explain:_____

Check any of the following conditions or symptoms you have experienced:

- ❑ Lower Back Pain
- ❑ Neck Pain
- ❑ Mid-Back Pain
- ❑ Arm Pain or Numbing
- ❑ Leg Pain or Numbing
- ❑ Headaches
- ❑ Dizziness
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Loss of Sleep
- ❑ Stabbing/Sharp Pain



Females Only:
When was your last period? _____
Are you pregnant? ❑ Yes ❑ No ❑ Maybe

Please outline on the diagram the areas of your complaints.

❑ Other

_____

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (*relief care*). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (*corrective care*). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (*comprehensive care*). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ Relief Care ❑ Corrective Care ❑ Comprehensive Care ❑ Check here if you want the Doctor to select the type of care appropriate for your condition.

If this is a motor vehicle accident related injury, please fill out the Accident Form.
If this is a work related accident, a Worker's Injury Claim Form must be completed.
Thank You!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Ballard Chiropractic Clinic, PS will prepare any necessary reports and forms to assist me in filing claims to the insurance company and that any amount paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that finance charges will be applied on accounts past due. Finally, I authorize the release of my records when requested by insurance carriers or attorney offices that may help in the processing of claims and/or payment.

Patient's Signature **X** _____ Date _____

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INFORMED CONSENT for CHIROPRACTIC ADJUSTMENTS and CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named above and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the Doctor of Chiropractic named above, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvements of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____
patient name	patient's parent or guardian name
_____	_____
signature of patient	signature of parent or guardian
_____	_____
date signed	**date signed**

To be completed by doctor or staff:

_____ _____

doctor or staff signature date